Isle of Wight NHS Trust

Use of Resources assessment report

St Mary's Hospital
Parkhurst Road
Newport, Isle of Wight
PO30 5TG
Tel: 01983 524 081
www.iow.nhs.uk

Date of publication:

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the trust.

Ratings

Overall quality rating for this trust	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/R1F/reports)

Are resources used productively?	**Inadequate**

Combined rating for quality and use of resources	**Requires improvement**

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was requires improvement:

- The trust was rated Inadequate for use of resources. Full details of the assessment can be found on the following pages.

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Date of site visit:
21 May 2019

Date of NHS publication:

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous 12 months, our local intelligence, the trust's commentary on its performance, and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

Are resources used productively?	**Inadequate** ●

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 21 May 2019 and met the trust's leadership team including the chief executive and the chair, as well as relevant senior management responsible for the areas under this assessment's KLOEs.

Summary of findings

Is the trust using its resources productively to maximise patient benefit?	Inadequate

We rated Use of Resources as inadequate. The trust is one of the smallest in England and delivers a unique portfolio of services. It operates within a constrained environment and challenged health economy. During our assessment, we found that the trust had one of the highest overall pay costs per weighted activity unit nationally and one of the highest percentage deficits nationally. The trust had significantly invested in its services over the last two years to improve quality and safety, however, there was not strong evidence that the investment had materially improved productivity. Progress was required in all KLOE areas, although we noted a number of elements of good practice and the trust's clinical support services generally benchmarked well.

- The trust was the seventh smallest trust in England (based on turnover) and was the sole integrated trust in England providing a unique portfolio of services: acute, mental health, community and ambulance services. The trust had been in special measures for quality since February 2018 and had been placed in special measures for finance in February 2019. Over the previous eighteen months, the trust had seen significant changes to its leadership with a considerable focus on improving the quality of its services.

- The trust operated within a challenging health economy due to its geography, demographics but also models of care with concerns over quality and finance. At the time of the assessment, the local health system was working jointly to develop a common sustainability plan to provide sustainable quality care to the local population.

- The trust had the second highest overall cost per weighted activity unit (WAU) driven by the highest pay cost per WAU nationally although the trust benchmarked in the second lowest (best) quartile nationally for non-pay costs. The trust had worked with NHS Improvement to assess the impact of its community, ambulance and mental health services on the pay cost per WAU which the trust believed was driving the high cost. However, at the time of the assessment, further work was required to conclude on the impact of these non-acute services on the pay cost per WAU.

- The trust benchmarked well nationally on emergency readmission, pre-procedure elective bed, Did Not Attend rates, elective length of stay and the proportion of procedures carried out as a day case. The trust had engaged well with the national Getting It Right First Time programme.

- However, at the time of the assessment the trust did not meet any of the four constitutional standards. The emergency length of stay was one of the highest nationally. The trust still had significant progress to make to fully benefit from the integration of its services and work with system partners to reduce length of stay and ensure patients are treated in the most appropriate setting. The trust had also identified further areas to improve its theatre productivity.

- The trust faced significant workforce challenges resulting in a high pay cost per WAU driven by both agency and substantive staff costs. The trust had high vacancies resulting in high agency spend, more than twice the ceiling set by NHS Improvement for 2018/19.

The trust had a good retention rate, although this contributed to increased pay costs due to staff's long length of service. The trust had a poor sickness rate and poor staff survey results. The trust used e-rostering to deploy staff on most wards, however further progress could be made to better use the data available from e-rostering in particular to try and reduce reliance on agency staff.

- The trust had taken a number of actions to address the issues above. However, at the time of the assessment, these had not materially improved the financial position of the trust. The trust was however continuing its effort, in particular to reduce agency spend as part of its cost improvement in 2019/20.

- The trust benchmarked well on clinical support services. The cost of medicines per WAU and cost per imaging report were in the lowest (best) quartile nationally. However, the trust's Laboratory Information Management System (LIMS) represented a significant risk and needed to be replaced urgently.

- The trust's corporate functions showed a mixed picture. The cost of the finance function benchmarked high compared nationally and slightly higher than the peer benchmark and the trust believed this also resulted from the specific requirements of four very different services. The cost of the human resource (HR) functions benchmarked in line with the national median when looking at the HR cost per employee although overall the cost of the function related to turnover was high but reflected the trust's small size. The trust's information management & technology function benchmarked well on cost although the digital maturity of the trust indicated that further investment was required. The estates and facilities management benchmarked well overall and the trust now needed to develop its estates strategy once there would be clarity on the future configuration of clinical services. The trust had low supplies and services cost per WAU and shared its procurement function with mainland trusts.

- The trust's financial position had deteriorated further during 2018/19 to a deficit of £30.1 million (excluding Provider Sustainability Funding (PSF)) which was one of the worst percentage deficits in England and £13 million worse than plan. The main driver of the deterioration was continued investment (£9.2 million) to improve quality and safety. Although the trust had achieved a higher-level savings in 2018/19 compared to prior year, the level of recurrent savings had decreased. Overall, the trust had an underlying deficit estimated at £34.4 million (19.6% of turnover). The trust had developed a financial plan to improve its overall financial position during 2019/20 although it relied on significant savings to be delivered recurrently and at the time of the assessment, 24.8% of savings were still unidentified and a third of the cost improvement plan relied on reducing agency spend.

How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

The trust benchmarked well on a number of metrics and had taken some actions to improve where it did not. However, this had not translated into material improvement in its operational performance with the trust achieving none of the operational standards at the time of the assessment. The trust had long length of stay for non-elective patients and stranded patients. It had significant progress to make to fully benefit from the integration of its services and work with system partners to reduce length of stay and ensure patients are treated in the most appropriate setting.

- At the time of the assessment, in May 2019, the trust did not meet any of four constitutional standards. The trust had consistently delivered below the 4-hour A&E standard with a performance of 78.9% in May 2019. Attendance at the trust's emergency department (ED) was very variable with a significant influx of tourists during the summer holiday season. The trust had strengthened its nursing and medical staffing and improved flow within ED through clinical streaming to try and improve its performance.

- The trust had last met the 18-week referral to treatment standard in September 2017 and had been significantly below the national average and recommended peers since. Key areas of underperformance were urology, trauma & orthopaedics, general surgery, cardiology and ophthalmology. The waiting list had increased by 1,387 patients (15%) between March 2018 and March 2019 meaning the trust did not meet its target to maintain or reduce the waiting list over 2018/19. The trust also anticipated the waiting list would increase further in 2019/20, indicating capacity and system-affordability as the main reasons for this. The trust was working with its commissioners to develop plans to enhance demand management schemes.

- The trust had last met the cancer 62-day wait in March 2018 and performance had continued to vary due to the relatively small number of patients treated at the trust per month and a significant increase in urology and endoscopy referrals. The trust had also experienced issues with diagnostics for urology patients. The trust had plans in place to meet the cancer 62-day target by October 2019 and was also working with external support to review and improve its cancer pathways with a particular focus on urology.

- The trust was not meeting the diagnostic 6-week waits at the time of the assessment having experienced recent reporting issues. The trust however expected to reduce its backlog and achieve the target during the summer 2019 although this required additional resources.

- For the year to December 2018 fewer patients were coming into hospital unnecessarily prior to elective treatment compared to most other hospitals in England, however more patients were waiting in hospital unnecessarily prior to non-elective treatment. On pre-procedure elective bed days, at 0.07 days, the trust was performing in the lowest (best) quartile nationally with the national median at 0.13 days. Opening a dedicated admissions unit for theatres had contributed to this performance.

- At 0.73 days for pre-procedure non-elective bed days, the trust was performing slightly worse than the national median (0.66 days). The trust was trialling the introduction of a CEPOD list (a regular, staffed operating theatre operating regularly over the week and shared amongst surgical specialities to conduct urgent or emergency operations) to avoid patients waiting unnecessarily prior to non-elective treatment.

- The Did Not Attend (DNA) rate for the trust at 6.56% (quarter 4 2018/19) benchmarked slightly better than the national median. The trust recognised that it benefited from a population who generally attend planned appointments but also had systems and processes in place including a text message reminder service and e-referrals from GPs. Further improvements were also planned through a digital portal and the introduction of text messages for mental health appointments.

- The trust had engaged well with the 'Getting it Right First Time' (GIRFT) national programme. The national GIRFT team had carried out 14 visits across a number of specialties and their recommendations were being considered by clinicians. The trust explained it had utilised GIRFT recommendations to implement improvements to clinical practices. An example was pathway redesign within urology to support transition from

inpatient to day-case procedures. The trust had recently implemented its GIRFT governance arrangements to ensure recommendations were considered and implemented to improve productivity across its services.

- The trust improved its theatre utilisation rate from 60% in December 2017 to 74% in February 2019. Progress had been made through closing unused theatre sessions, utilising '6-4-2' theatre scheduling meetings and e-signing off of all lists. However, pre-assessment required more focus to improve this further. The trust had worked with an external company to review its theatre productivity which had identified opportunities for productivity improvement with an estimated £0.3-0.4 million savings potential. The trust also benchmarked well on day cases, being in the second highest (best) quartile nationally.

- The trust had introduced new technology to help improve clinical productivity. For example, the trust had introduced an ambulance computer-aided logistics system which had improved handover times. Telehealth was being used in innovative ways and the remote monitoring of frail elderly patients across 18 care homes had reduced the number of emergency admissions and improved patient experience. Additionally, dysphagia assessments were being carried out remotely which had reduced admissions to the hospital and travel time for patients.

- For the year to December 2018 the trust's emergency readmission rate was 7.42% placing it in the second lowest (best) quartile nationally. This meant that patients were less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally. The trust's low readmission rate had, however, to be seen in the context of high non-elective length of stay and the number of stranded and super-stranded patients at the trust.

- The trust's delayed transfers of care (DTOC) rate was 2.4% in October 2018 performing in the second lowest (best) quartile nationally although the position had deteriorated during quarter 4 2018/19 (to 5.5% in April 2019) due to infection control issues in partner organisations and the closure of nursing home beds. All stranded and super-stranded patients were reviewed on a twice weekly basis and each ward area had a patient navigator to facilitate discharge. Although the trust benchmarked in the lowest (best) quartile nationally for elective length of stay (LoS), it had the 12th worst non-elective LoS for emergency admissions nationally (11.5 days compared to 9.3 days nationally in September 2018). A bed audit carried out externally in December 2018, had identified that 43% of all patients on that day had been fit for discharge for at least one week. This highlighted a mismatch between the DTOC numbers reported and the high level of medically fit for discharge patients in wards and raised question of a possible lack of robust processes to recognise DTOCs. The review also highlighted a number of systems and processes issues across the health and social care systems as well as internal leadership, capabilities and behaviour.

- The trust was in a unique position as an integrated trust to leverage its services to operate efficiently. The trust was able to provide a number of examples where working across the various services had been successful (e.g. integrated sepsis pathway with paramedics starting treatment; pro-active cardiac care in the community services) although they recognised that further work was required to better integrate the services. A review of clinical services done in December 2018, also identified that the trust had a higher level of acute services compared to other providers and that further work was required to develop community and mental health services which would help address the sustainability of services and improve quality of care by treating patients in the best setting.

How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

The trust had the highest overall pay cost per WAU nationally driven by the length of service of staff at the trust and the highest agency cost per WAU in England. The trust relied on agency staff to deliver its services at high cost to the trust. The trust benchmarked well on retention although this was in the context of a poor sickness rate. The trust could also do more to exploit e-rostering and job planning to efficiently deploy staff.

- For 2017/2018, the trust had an overall pay cost per WAU of £2,819 which was the highest nationally and compared to a national median of £2,180. This meant that it spent more on staff per unit of activity than all other acute non-specialist NHS trusts. Although the level of agency spend was the primary driver of the high pay bill, the substantive staffing costs were also high. The trust had investigated the drivers of this cost, however further work was required to confirm that impact of community, ambulance and mental health services on the cost to be able to benchmark the trust nationally.

- The staff retention rate at 87.7% for the year to December 2018 was better than the national median of 85.6% and benchmarked in the higher (best) quartile nationally. With staffing retention being high and to ensure that skills remain refreshed the trust offered rotational opportunities for staff to hospitals on the mainland (e.g. special care baby unit for nursing, surgeons working at mainland hospital), support from clinical networks (e.g. mental health) and from consultant medical staff who were in and outreach. The trust also ensured performance management was appropriately followed to keep the right staff.

- The trust's agency cost per WAU at £232 for 2017/2018 benchmarked in the highest (worst) quartile nationally at more than twice the national median of £107. At the end of March 2019, the trust's proportion of total staff spend that is on agency staff (8.28%) was in the highest (worst) quartile nationally with a national median of 5.01%. The trust's agency spend was also significantly above the spend ceiling set by NHS Improvement (£11.7 million in 2018/19 compared to a ceiling of £4.6 million). The trust had a master vendor contract in place which had delivered cost avoidance of circa £118 thousand per month since its implementation in November 2018 (circa £1.4 million annualised) and the trust had also reduced the number of agency staff in the community mental health team through a service/skill mix review. Agency spend reduction was a core part of the cost improvement plan (CIP) for 2019/20, with the trust anticipating £4.0million savings.

- During our assessment, the trust demonstrated that nursing staffing were redeployed across the organisation to maintain patient safety while avoiding agency costs, although the trust was unable to quantify the impact this had on agency cost avoidance. The trust utilised e-rostering for 80% of its wards with up to eight weeks sign off in advance and e-rostering review meetings to deploy staff effectively. However, the trust recognised that the management of the remaining 20% could be improved and it was not yet systematically using the information available from e-rostering in order to maximise the reduction in agency usage. The trust was focusing on improving the use of e-rostering and collaborative bank as a means to reduce agency cost as part of its 2019/20. The trust had an internal bank for both medical and nursing staff with 82% fill rate for nursing staff. The trust was also committed to the collaborative bank with other trusts within the Sustainability and Transformation Partnership (STP) on the mainland.

- The trust had some initiatives in place to improve recruitment and reduce dependency on temporary staffing. These included overseas recruitment, stricter controls on agency spend, alternative workforce models, options for nurses to work flexibly and rotate to the

mainland, nursing associates and clinical apprenticeships. Although these initiatives had delivered benefits such as recruitment to some of the registered nurses and consultant vacancies, further progress was required to improve the overall workforce vacancies and significantly reduce the level of agency spend.

- The trust's sickness absence rate for the year to November 2018 was 5.6%, the 4th highest rate nationally with a national benchmark of 4.35%. The trust cited the main reasons for sickness absence as stress, anxiety and musculoskeletal conditions. The trust had invested in support to divisions through a Human Resources Business Partner model working with service managers and promoting a health and well-being approach. The trust had also appointed a mental health practitioner and a direct referral physiotherapist to support employees. This was also to be seen in the context of the last staff survey for 2018, which showed poor results in particular in areas such as staff engagement and health and wellbeing, safe environment. The trust had in place monthly pulse surveys which showed progress since November 2018, in particular in recommending the trust as a place to work and engagement of staff in suggesting improvements.
- The proportion of total consultants with an active job plan for 2017/18 was 51%. During 2018/19 a job planning policy had been introduced and clear leadership of the process had been devolved to Care Group Directors. Further work was being done to increase the rate of active job planning and ensure team job planning reflected demand and capacity planning.

How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?

The trust benchmarked well on pharmacy and imaging services. Incomplete data on pathology meant we could not fully assess the trust's relative position. The trust however needs to progress with replacing its Laboratory Information Management System (LIMS) as a matter of priority. The trust had evidence of the use of innovative technology to improve its clinical services.

- The trust had not submitted the full set of pathology data for 2017/18, which meant that we could not fully assess the trust's relative position. However, data submitted indicated that the overall cost per test for 2017/18 at £1.89 per test was lower than the national median of £1.92 but significantly higher than a peer median of £1.57. Microbiology cost per test was also £10.67 compared to a national median of £4.27 and a peer median of £5.46. The trust was engaged with Pathology Network 6 to implement the recommendations from the Lord Carter Review into operational productivity in the NHS through delivery of a hub and spoke model. The trust's Laboratory Information System (LIMS) was over 25 years old which represented a risk to patient services. As a result, this was on the trust risk register. To mitigate and reduce risk of potential failure of the system due to age, the trust had purchased a secondary hardware in 2018 to provide business continuity for the current outdated LIMS which held a mirror of the data on the live LIMS to mitigate against the impact of system failure. However, at the time of the assessment, this still needed to be tested by the clinical staff. The trust is very aware of the critical nature of the LIMS and has learnt lessons from the Leeds LIMS failure of 2016. The trust's LIMS is on its risk register, mitigation measures are in place, additional LIMS support measures have been installed and applications for additional funding have been made.

- The LIMS has not yet been replaced due to identifying capital opportunities with Southern Counties Pathology (South of England Network 6) to purchase a collective LIMS. A collective proposal has been drafted and awaits future capital applications

through the HIOW STP. A new funding request through the STP IT funding has been made with notification expected in September 2019 as to the success of the bid. The trust had delivered £0.251 million savings over the last two years with a reduced amount in 2018/19. The trust was planning to deliver £90,000 savings in 2019/20.

- The trust benchmarked well on pharmacy services with a medicine cost per WAU for 2017/18 of £261 compared to a national median of £309, placing the trust in the lowest (best) quartile nationally. The trust's Hospital Pharmacy Transformation Plan (HPTP) had ten priorities; this included a centralised medicines distribution hub in collaboration with two nearby mainland trusts. The governance of the HPTP linked to finance, and the pharmacy managers regularly network with pharmacy medicines optimisation leads across the region. The HPTP had also included the development of a 7-day pharmacy service at the trust without additional resources required to deliver it.

- The trust had saved £1.7 million for the year 2017/18 and an additional £0.5 million in 2018/19. The largest savings for 2018/19 related to Adalimumab biosimilar transition. Savings made from switching drugs to biosimilars were shared with the local commissioners. The chief pharmacist also met its counterparts monthly, which allowed to share ideas on savings.

- For imaging services, the overall cost per report at £45.18 is in the lowest (best) quartile nationally compared to a national median of £50.05 although it is slightly higher than peers (£43.28). However, the trust had not submitted data relating to a number of metrics relating to imaging, so we were not able to benchmark specific elements of the service. The trust benchmarked well on age of equipment except for non-obstetrical ultrasound with half its machines over 6 years old. The trust did not provide the value of savings achieved during 2018/19 for imaging services. However, they explained that they were looking for cost avoidance by considering options to replace a mobile MRI scanner that was previously needed to meet waiting times in 2018/19 and was expensive. The trust explained that they benchmarked well on the cost of the service with limited areas to deliver savings.

- For 2017/18 the trust's level of auto-reporting for plain X-ray was 37.3% compared to a national median of 12.7%, placing the trust in the highest (worst) quartile nationally. Auto-reporting could place patients at risk with avoidable misdiagnosis. The level of auto-reporting had been reduced through training reporting radiographers within the existing workforce. The level of reporting by consultants was low placing the trust in the second lowest (worst) quartile nationally. The trust had a low number of radiologists who provided advice to clinical teams as well as carrying out reporting. The trust used technology to enable home working for consultant radiologists to protect their time on reporting and had one radiologist working remotely from the mainland. The trust had also been successful in recruiting two radiologists expected to join in July 2019 and was a rotational site for trainees.

- The trust provided examples of innovative use of technology to deliver their services. The trust had a dedicated digital workstream. It had implemented Skype for standard follow up outpatient appointments to reduce pressure on clinic space and unnecessary travel for patients. For patients with dysphagia, the trust had developed a tele-swallowing monitoring service. The trust had also extended e-prescribing into community pharmacy to reduce medication errors and incidents and there was also a supporting medicines helpline for patients and pharmacists.

How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

The trust's non-pay costs per WAU benchmarked in the second lowest (best) national quartile. However, the trust provided a mixed picture with regards to its corporate services. The trust benchmarked higher than the national median in relation to turnover, reflecting the complex nature of the trust's activities and small size. The trust benchmarked well on information management & technology costs although its digital maturity shows areas for improvement. The trust's estates benchmarked well against peers and the trust needs to develop its estates strategy once the clinical strategy is known. The trust has low cost of supplies and services and uses a shared procurement functions with nearby trusts although there are further areas where savings could be achieved.

- The trust's non-pay costs per WAU for 2017/18 benchmarked in the second lowest (best) national quartile, better than the national median at £1,307, although the relative position compared to other trusts nationally had deteriorated compared to prior year when the trust benchmarked in the lowest (best) quartile nationally. The low non-pay cost per WAU reflects low cost of medicines (see above) and a cost of supplies and services of £302 which benchmarks in the lowest (best) quartile nationally.

- The cost of the finance function per £100m turnover is £0.988 million which was £0.250 million higher than the national median and benchmarked in the highest (worst) quartile nationally. The trust benchmarked worse than the national median on several specific areas of the finance functions such as the cost of the financial accounts and management accounting functions and external audit. The trust attributed these higher costs to the sub-scale size of the trust and higher administrative burden of hosting, in effect, four very different kinds of organisations within one trust – acute, community, mental health and ambulance. However, the peer median based on trust size (spend) at £0.922 million per £100m turnover would indicate that there may be further opportunity to reduce the cost of finance function.

- The trust had outsourced its accounts payable and receivable functions and as a result it benchmarked well on the cost per payable and receivable invoices. The trust benchmarked better than the national median on project management office although an external review carried out in April 2019, identified that the trust appeared under-resourced on this. The trust had integrated networks with commissioners and local authority, providing them the service for which it received income. The trust however indicated that it continued to look to further consolidate financial services with commissioners and local authority to further derive efficiency savings.

- The human resources (HR) function cost per £100m turnover was £1.22 million and benchmarked higher than the national median of £1.104 million. However, the cost of the HR function per number of trust full time employee (whole time equivalent (WTE)) was £792 and was in line with the national median.

- The trust benchmarked high compared to other trusts nationally in several areas. The average time taken to close employee relation cases was 41 weeks, double the national upper quartile (19 weeks) and the trust had improved the management and oversight of case management including through regular case reviews and key performance indicators. During 2017/18, only 61% of staff had received an annual appraisal (compared to a national median of 83%) and 80% had completed the required statutory and mandatory training (compared to a national median of 89%). The trust had implemented an improvement plan in 2018/19 which had resulted in some improvements to 77% for annual appraisals and 86% for statutory and mandatory training. The cost of

the trust's in-house occupational health service benchmarked in the highest (worst) quartile nationally with the number of occupational health appointments per employee (WTE) more than twice the national median. The trust explained this may be due culturally to staff relying on the in-house occupational health service rather than seeing their GP but this needed to be evidenced.

- The cost of the trust's fully outsourced payroll service at £84 thousand per £100 million turnover was in line with the national median. However, the number of payroll errors in 2017/18 (by managers, staff and payroll team) all benchmarked in the highest (worst) quartile nationally. The trust recognised that improvement could made with the management of the service contract and a plan was in place to do so, driven by the Director of HR.

- The trust benchmarked low on the cost of the information management and technology (IM&T) function at £1.462 million per £100 million turnover compared to a national median of £2.508 million. However, the trust's digital maturity assessment showed a wide range of areas requiring investment and improvements. Considering the nature of its location, the trust needed to invest in its digital services to support and align with its recovery plan.

- The cost of the estates & facilities function benchmarked well at £279 per square metre (m2) compared to a national median of £359 per m2. Hard facilities management (FM) were in line with the national median at £83 per m2 and soft FM was very low at £67 per m2 compared to national median of £103. Overall, the trust benchmarked well on the majority of estate and facilities metrics being an outlier on water, sewage and waste which reflected the constraints from being on an island. The trust, however, was working with the local authority to take opportunities from the redevelopment of the incineration plant to reduce the cost of waste.

- The estates strategy depended upon the development of a clinical strategy within the local health systems. However, the trust had already identified approximately 32 acres of surplus lands with potential future uses to support trust staff, for example by providing housing for staff or extra care environment to depressurise the system (e.g. care homes, creche etc).

- The critical infrastructure risk per square meter was in line with the national median (£55 for both) and was managed through planned and preventive maintenance (PPM) with reporting to a dedicated sub-group and ultimately to the trust board.

- The supplies & services cost per WAU benchmarked in the lowest (best) quartile nationally at £302 compared to a national median of £364. The trust utilises a shared procurement function (South of England Procurement Services) to gain access to specialist procurement expertise and improve opportunities for collaboration with other NHS organisations and during 2018/19, it had made total procurement related savings of £1.7 million with significant cash releasing savings achieved through switches to nationally contracted products that year. The cost of the function per £100 million turnover was double the national median, although the trust indicated that this included the cost of a contract management service provided by a legal team within the consortium.

- However, the trust's position on the NHS procurement league table (84th out of 133 trusts) and the trust's Price Performance Score of 33.3 (compared to a national median of 50.5) would suggest there were further opportunities to achieve competitive prices on

the goods it purchased. The trust acknowledged that more could be done on product standardisation across the trusts in the shared procurement function.

How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

The trust had delivered deficits for several years and required cash support from the Department of Health & Social Care to meet its financial obligations. The trust had been placed in special measures for finance by NHS Improvement in February 2019. The trust had made significant investments in quality and safety over the last two years although it was not always clear the impact such investments had had. The trust had improved the level of savings delivered and improved the operations of its Project Management Office although the level of recurrent savings, which could improve its underlying financial deficit, had decreased and the trust had an ambitious Cost Improvement Plan for 2019/20 with a significant part remaining unidentified.

- In 2018/19, the trust had not accepted a £1.7 million deficit control total set by NHS Improvement (excluding Provider Sustainability Funding (PSF)) and delivered a £30.1m deficit (no PSF received), £13 million worse than plan and representing 17.1% of turnover, one of the highest nationally as percentage of turnover.

- This represented a material deterioration on 2017/18 when the trust delivered a £23.7 million deficit (excluding Sustainability and Transformation Fund) against a planned deficit of £18.8 million. The deterioration during 2018/19 compared to plan was mainly driven by ongoing significant investment (£9.2 million) mainly to address the safety and quality issues which resulted in the trust being placed in special measures for quality, under-delivery of its cost improvement plan (CIP) and the cost of unfunded activity (e.g. escalation beds during the winter).

- For 2019/20, the trust had developed a plan to deliver a £21.5 million deficit (excluding non-recurrent central funding; £4.0 million deficit including non-recurrent central funding). The 2019/20 plan included £2.0 million further quality investment and was supported by £12.9 million CIP (£10.5 million of new schemes to be implemented in 2019/20 and £2.5 million of full year impact of prior year schemes). At the time of the assessment, the trust was not able to articulate the extent to which the investment made during 2017/18 and 2018/19 had improved the quality, safety and productivity of its services. However, the trust had developed a framework to review, prioritise and measure the impact of the 2019/20 investments. Risks remained that further investments in quality/safety, above the £2 million reserve, would be required to further progress at pace on quality and financial improvement.

- Following the trust's material deterioration of its 2018/19 position, the trust had been placed in special measures for finance by NHS Improvement in February 2019 and required, in particular, to build a robust understanding of the drivers of its underlying financial position, improve financial controls and develop a financial recovery plan.

- The trust's 2017/18 underlying position had been estimated externally at £25.9 million, had increased to £34.4 million at the end of 2018/19 but would decrease to £13.5 million in 2019/20 providing the trust delivered £19.7 million recurrent savings (full year impact) during that year. The external review carried out in 2017, had linked part of the trust's underlying financial position to wider issues within the local health system, not fully within the trust's control to address. At the time of the assessment, the trust, its main commissioner and local authority had developed a high-level sustainability plan laying out the case for change and identifying options to improve care models, productivity and

develop networked services. This however needed to be further developed into specific actions and implemented to deliver the anticipated benefits.

- Over the last two years, the trust had delivered increased savings from £5.4 million (2.7% of expenditure) to £6.8 million in 2018/19 (3.2% of expenditure) and from 44% of its plan to 85% in 2018/19. The level of recurrent savings, which would have improved the trust's underlying financial position, had however decreased from £5.3 million to £3.7 million during that time.

- During 2018/19, the trust had secured external support to develop a project management office (PMO) and identify efficiency savings. An external review of the internal PMO in April 2019, praised the level of engagement of the team although it also identified areas where the trust had to improve the PMO's effectiveness.

- For 2019/20, the trust had a £12.9 million CIP (6.3% of expenditure), all schemes recurrent, which included £2.5 million full year impact from prior year schemes and £10.5 million of new schemes to be implemented during 2019/20. The trust's 2019/20 CIP included schemes identified at divisional level (0.5% cost reduction target), cross organisation opportunities (e.g. reducing agency spend) and schemes agreed at system level (supporting return to home and prescribing). At June 2019, a number of divisions had identified plans exceeding their target, however, overall, only 32% of the £10.5 million plan had been fully validated after assessing the impact on quality and 24.8% of the plan remained unidentified. More than a third of the trust's plan relied on reducing agency spend.

- The trust relied on cash support from the Department of Health and Social Care (DHSC) to meet its financial obligations and pay its staff and suppliers in the immediate term. The trust had received £30.1 million cash support from the DHSC during 2018/19 and the trust expected to decrease the additional support required in 2019/20 to £4.0 million providing the trust delivered its 2019/20 planned financial position and received £17.5 million of non-recurrent central funding (Provider Sustainability Funding, Financial Recovery Funding and MRET). The trust managed its cash position daily and had payment plans approved with suppliers during 2018/19 to help manage its cash position.

- The trust had Service Line Reporting in place although, at the time of the assessment, the trust recognised that the information was not widely shared across the organisation and the culture needed to change for clinicians to be fully engaged in the process and review of services.

- The trust received commercial income from various services (e.g. occupational health, NHS Creative, a marketing service for the benefit of the NHS, car parking and catering), had started to consider how to maximise its commercial income and was reviewing its commercial income function. The trust, however, recognised that not all its commercial services were profitable but needed to identify alternative options for such services.

- The trust consultancy spend had increased between 2017/18 to 2018/19 from £1.6 million to £2.9 million reflecting that the trust was in special measures for quality and was financially challenged. The trust had received £0.4 million from NHS Improvement's special measures funding against this spend in 2018/19. The trust had received support from a number of external parties to develop and run a PMO, identify savings and productivity opportunities and develop a sustainability plan with system partners. Consultancy spend was expected to reduce in 2019/20 to £1.2 million. The trust had also received advisory support from regulators. At the time of the assessment, however, there

was not clear evidence how this advice had been evaluated and systematically followed through to improve on the quality and financial position.

Outstanding practice

During our assessment we identified several outstanding practice areas. Below are some of the key or most innovative ones:

- The trust has developed a tele-swallowing remote monitoring service for patients with dysphagia.
- The trust has implemented a Computer Aided Despatch (CAD) system in partnership with South Central Ambulance Service (SCAS) which has improved handover times.
- The trust has utilised Electronic Prescribing and Medicines Administration technology to improve communication regarding discharge medicines to community pharmacy in line with the Wessex Academic Health Science Network "TCAM" project in order to reduce the risk of a medicines related incident post discharge. A medicines phoneline has also been introduced to support patients and the wider healthcare team.
- Telehealth has been implemented to remotely monitor frail elderly patients across 18 care homes and reduced emergency admissions and improve patient experience.
- Protocol for paramedics to start giving antibiotics where sepsis is suspected in patients.

Areas for improvement

The following have been identified as key areas where the trust has opportunities for further improvement:

- The trust must further develop and implement the health economy sustainability plan with its local partners at pace. This should include robust governance arrangements and necessary resources for delivery.
- In particular, the trust must continue to work at the local economy level to reduce length of stay and address delayed transfers of care, according to the options identified in the Isle of Wight health and care sustainability plan (“the health economy sustainability plan”).
- The trust must continue to identify opportunities to integrate its four core services to ensure that patients are treated in the correct setting – this should reflect the findings of the health economy sustainability plan.
- The trust must progress in identifying and validating the rest of its cost improvement plan for 2019/20 including development of a pipeline of schemes.
- The trust must ensure DTOC rates reflect the position at the trust and investigate discrepancies with medically fit for discharge patients.

- The trust must develop its use of e-rostering to optimise the deployment of staff and reduce the reliance on agency staff.
- The trust must continue its effort to identify actions to improve recruitment and reduce vacancies and reduce the level of agency spend across the trust.
- The trust must ensure staff have followed statutory mandatory training.
- The trust must improve the level of consultants with an active job plan and should progress with linking job planning to demand and capacity planning.
- The trust must engage with the Pathology Network 6 to accelerate the timescales to replace its LIMS.
- The trust must ensure that auto-reporting in radiology is kept to a minimum to reduce the risk of mis-diagnosis.
- The trust must continue to identify areas for integration of its back-office services with local partners and where appropriate mainland trusts.
- The trust must continue to develop its service line reporting and patient level costing systems and engage with clinicians to review services, support the identification of efficiencies and provide information for decision making.
- The trust should continue to assess and implement the recommendations made by Four Eyes Insight on areas where the trust could improve its theatre productivity.
- The trust should ensure it has appropriate contract management in place for its payroll services to see a reduction in the number of payroll errors.
- The trust should consider working with the shared procurement function to improve the standardisation of products across the trusts sharing the function.
- The trust should ensure its project management function has the appropriate capacity to support the identification, delivery and oversight of its cost improvement plan for 2019/20.
- The trust should consider how it assesses, prioritises and manages the delivery of the recommendations made through the interventions and support from external parties to ensure it delivers the intended benefits.

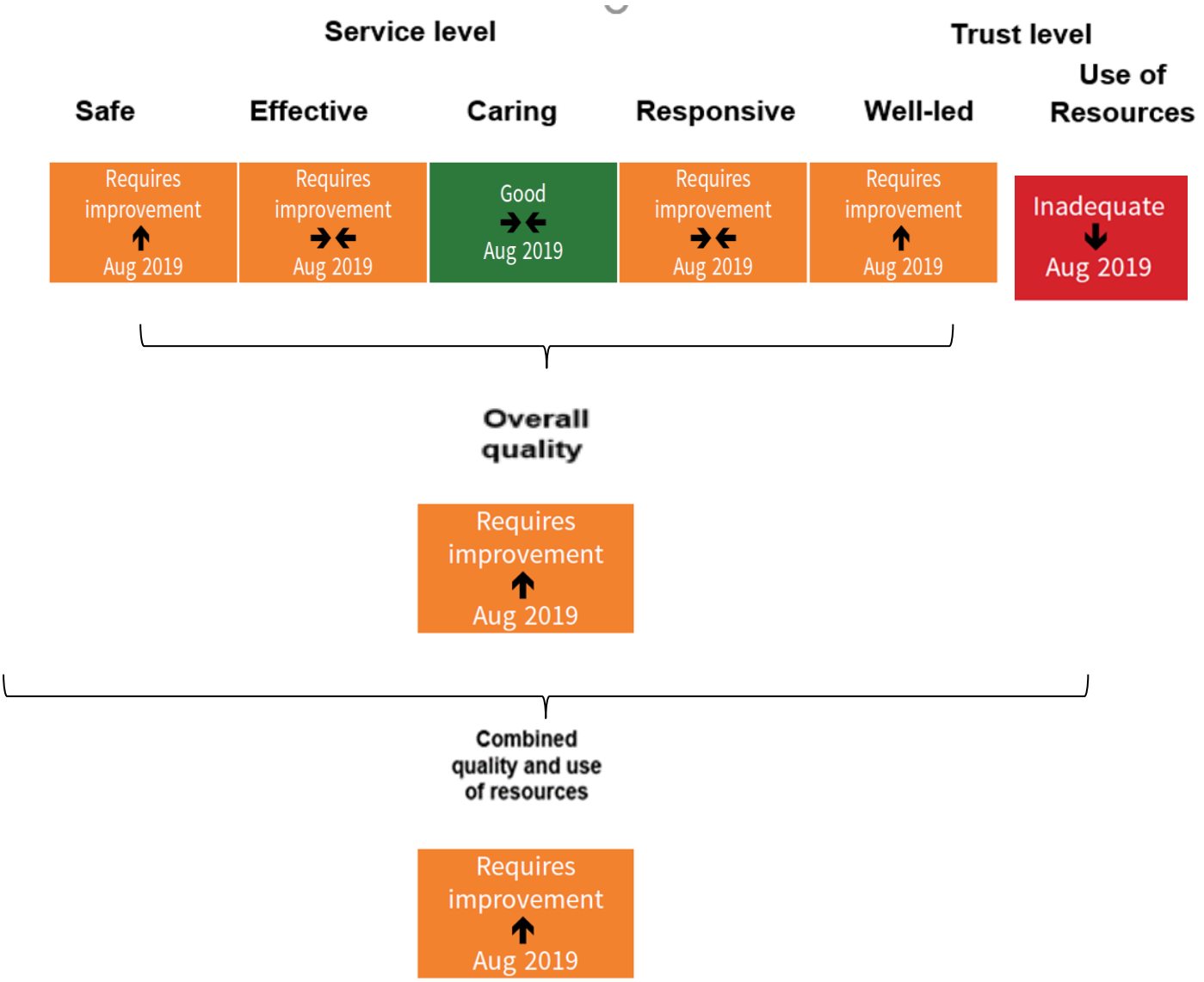
Ratings tables –

Key to tables					
Ratings	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**	
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = date key question inspected					

***** Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term 'allied health professional' encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24 hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.

Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR)	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.

cost per £100 million turnover	
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs

Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.